The Short-Doyle Act

California Community Mental Health Services Program: Background and Status After One Year

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• **The Short-Doyle Act seeks to encourage the treatment of a patient suffering from a psychiatric disorder in his home community, with the assistance of local medical resources. One corollary of this program is the closer working together of the psychiatrist and the rest of the medical profession.**

A second goal of the act is the application of the public health principles to mental illnesses and mental retardation. Educational and consultative services provide implementation of these principles.

IN RECENT YEARS there has been a striking change in attitude regarding the care and treatment of persons with psychiatric disorders. The present concept is that mentally ill persons, instead of being sent to distant state hospitals, should be treated near their homes, close to family and friends, whenever possible. Acting on the theory that inpatient and outpatient psychiatric treatment in the ordinary general hospitals of the community achieves good results in a high proportion of cases, the California legislature has enacted legislation—the Short-Doyle Act—to initiate or expand community mental health services.

When a person becomes ill, whether through heart attack or broken leg, he expects to go to a local general hospital for treatment. It is now believed that most psychiatric illnesses can be treated in a similar setting, that general hospitals should provide facilities for psychiatric care just as they do for surgical and other medical care. It is believed that this would encourage the mentally and emotionally ill to seek help sooner and that faster recovery could be expected.

BACKGROUND

In 1955 the California Department of Mental Hygiene introduced Assembly Bill No. 1159, patterned after similar legislation passed in New York State in 1954. This measure was designed to establish a community mental health services program including outpatient and inpatient care, rehabilitation, education and consultation services. It passed the Assembly but was tabled in Senate committee. A Senate Interim Committee on the Treatment of Mental Illness was set up under Senator Short to study this matter and to bring in recommendations.

The California Medical Association also began a study of this problem. In May, 1956, a special committee was formed, consisting of Dr. Dan O. Kilroy, Chairman of C.M.A. Committee on Legislation, Mr. Howard Hassard, C.M.A. legal counsel, and Dr. Alfred Auerback, chairman of C.M.A. Committee on Mental Health. A letter was sent to nearly 1,000 psychiatrists throughout the state, asking their opinions on the need for a statewide community mental health services program, and requesting suggestions as to how such a program should be organized and financed. Some 250 answers were received, all expressing the need for this program. There were no dissents.

A series of meetings with physicians, psychiatrists and representatives of lay organizations interested in the mental health field gave the committee a clear picture of the unmet mental health needs in California. In the fall of 1956 the committee began to draft a proposed bill. Since the California Conference on Local Health Officers would be meeting jointly with the Department of Mental Hygiene to draft the regulations when the bill was enacted into law, Dr. Ellis D. Sox, Director of Public Health of San Francisco, as president-elect of the conference, was invited to help in its preparation. The proposed draft was reviewed by various interested groups and won acceptance from all. This suggested program was submitted to Senator Short and his committee, who accepted these recommendations in drafting the new bill. Senator Short introduced the measure in the Senate; Assemblyman Doyle simultaneously introduced it in the Assembly.

The Short-Doyle bill as passed by the legislature contained nearly all the recommendations of the C.M.A. The only major loss in its legislative passage was a section providing for state payments to cities or counties for the care of mentally ill patients who were treated locally even though they did not agree to undergo treatment. This section was intended to apply to patients who are so disturbed that they cannot cooperate voluntarily and therefore have to be

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confined, under court order in order to receive necessary treatment. The legislature felt that the program should be voluntary throughout, counties and cities having the right to choose whether or not to enter the program and patients also having free choice in accepting treatment.

PROVISIONS OF THE SHORT-DOYLE ACT

The Short-Doyle Act provides the means by which local governments wishing to establish a local mental health service may do so, with the state matching local funds dollar for dollar. A city or county may receive state reimbursement for 50 per cent of its net expenditures when it establishes at least two of the following services:

1. Three kinds of clinical facilities directly serving patients: (a) Outpatient services in clinics; (b) inpatient services in general hospitals for a period not to exceed 90 days; (c) rehabilitation services in clinics, general hospitals or special centers.

2. Two kinds of services promoting the mental health of the community: (a) Informational and educational services to the public and to the professions and agencies concerned with mental health; (b) mental health consultation for the staffs of schools, public health departments, probation officers, welfare departments and others to help them to deal more effectively with children's or client's mental health problems before they become severe enough to require psychiatric treatment.

Cities and counties may themselves operate these services or they may contract with a private general hospital, clinic, laboratory or other appropriate agency to provide them. Any person who is "unable to obtain private care," whether for financial, geographical or other reasons, is eligible for inpatient or outpatient care and psychiatric rehabilitation. No patient can be forced into treatment (within the provisions of the Short-Doyle Act) against his will or ordered into treatment by a court. Fees shall be charged in accordance with ability to pay, the local community establishing its own financial regulations. Patients who are under court commitment may be treated in the local general hospital but the community receives no state reimbursement for this treatment under the act.

Local Mental Health Authority

Both the option and the authority to establish local mental health services are given to:

1. Any county board of supervisors to establish services covering the entire county;

2. Any city council of a municipality with a population exceeding 50,000;

3. The board of trustees of a health district (applies only to San Joaquin County).

Joint Mental Health Services

Joint mental health services may be established by two or more counties, by two or more cities with a combined population in excess of 50,000, or by a combination of one or more cities with one or more counties. Joint mental health services may be jointly operated, or one participating city or county may contract to provide service for the others. Costs of services are to be apportioned on the basis of population.

Local Mental Health Advisory Board

Each local mental health authority (local governing body) must appoint an advisory board consisting of seven members: Three local physicians in private practice, of whom one shall be a psychiatrist where possible; the chairman of the local governing body; a superior court judge; and two persons "representative of the public interest in mental health."

The local mental health advisory board is given the responsibility to: (a) Review and evaluate the community's mental health needs, services, facilities and special problems; (b) Advise the governing body as to a program of community mental health services and facilities, and, when requested by such governing body, may make recommendations regarding the appointment of a local director of mental health services; (c) After adoption of a program, continue to act in an advisory capacity to the local director of mental health services.

One of three choices is offered to the governing body: The local administrator of mental health services must be a licensed physician and surgeon, but the administrator who is appointed may be either a specially qualified local director of mental health services, the local health officer or the medical administrator of the county hospital. In effect, the governing body has the choice of utilizing one of its two public medical agencies as the administrative setting for the local program of community mental health services, or the governing body may create a new mental health agency under a local director of mental health services.

Items Subject to State Reimbursement

Cities and counties may claim a state reimbursement of 50 per cent of the net amount expended from local funds for the following items:

1. Two or more of the five specific community mental health services authorized by the act (expenditures are subject to reimbursement whether the local governing body operates its services and facilities directly, or provides them through contract "or by other arrangement pursuant to the provisions of this division").

2. "Such inservice training as may be necessary in providing the foregoing services."

3. Salaries of personnel.

4. Approved facilities and services provided through contracts.

5. Operation, maintenance and service costs.

6. Actual and necessary expenses incurred by members of the local mental health advisory board.

7. Expenses incurred by members of the California Conference of local mental health directors for attendance at regular meetings of the conference.

8. "Such other expenditures as may be approved by the director of mental hygiene."

Certain items are specifically excluded by the act from state reimbursement:

1. Treatment services supplied to patients who are able to obtain private care.

2. The cost of confinement "incurred by reason of court procedures"—that is, expenditures for involuntary patients.

3. Inpatient services in excess of 90 days' duration.

4. Services employing a physician who is not a citizen of the United States.

5. Capital improvements.

6. Purchase or construction of buildings.

7. Compensation to members of the local mental health advisory board.

8. "Expenditures for a purpose for which state reimbursement is claimed under any other provision of law" (such as the special services in public schools that receive state aid through the State Department of Education, for example).

PRESENT STATUS

In the first 13 months, December 1, 1957, to December 31, 1958, eleven counties (Alameda, Contra Costa, Kern, Monterey, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sonoma, Ventura) and one city (San Jose) elected to enter the Short-Doyle program. During this past year these communities spent nearly $2,500,000, receiving almost $1,250,000 in state reimbursement. These communities represent 27.3 per cent of the total state population (4,126,000 persons). Near the end of 1958 the Board of Supervisors of the County of Los Angeles voted to enter the program; hence the counties containing a majority of Californians are now participating in the community mental health services program. As the first year of the Short-Doyle program ended, the boards of supervisors of Fresno and Marin counties voted to appoint mental health advisory boards and the city of Santa Monica voted to enter the program.

In a number of counties, study groups have been organized to explore local mental health needs without actual implementation of the Short-Doyle program. Among these are Solano, Kings, El Dorado, Shasta, Placer, Humboldt-Del Norte, Stanislaus, Tehama, Sacramento and San Benito. The city council of Berkeley has instructed the city manager to include a mental health program in the budget for 1959-60 and will consider it later this year.

In aggregate, the county and city programs now operating under the Short-Doyle Act are providing 42 services, including five inpatient services (146 psychiatric beds), fourteen outpatient clinics, three rehabilitation services and eight educational services. All of them are providing psychiatric consultation services to public agencies. Each community developed the services it required to meet local needs. Some areas focused on children's services, or on inpatient treatment or all-purpose clinics, while others stressed helping patients discharged from state hospitals.

Two pressing problems have appeared with the development of the community mental health service programs. The first is a shortage of trained personnel. There are not enough psychiatrists, psychologists, psychiatric nurses and psychiatric social workers to fill the existing vacancies. As more counties have entered the program the shortage has become more acute. In Monterey County, want of a psychiatric director has prevented operation of a 15-bed psychiatric ward. To meet these personnel shortages the Department of Mental Hygiene held a three-day conference in Berkeley last August, in which all the training institutions in the state participated. These included medical and nursing schools, public and private hospitals, universities and colleges providing education for doctors, nurses and psychiatric personnel. For the next few years the personnel shortages will have to be met through in-service training programs, until these training institutions can begin to provide an increasing number of qualified graduates.

The other pressing problem is that as soon as local services are organized they are overwhelmed by demands for assistance from all quarters. Every clinic has been swamped with referrals. Other community agencies such as the welfare and probation departments, the courts and the schools have sought trained psychiatric help for the many problems confronting them. Because of the heavy demand, every community mental health service has had to establish priorities on the number and the kind of patients that could be accepted for treatment. At the end of January 1959, key personnel of all the existing mental health programs in California met in San Jose to discuss their mutual problems. At this meeting the emphasis was on ways to meet this particular problem and how to provide more psychiatric consultation and guidance to agencies in handling their own

case loads. This group will meet at regular intervals to try to find solutions to the many other problems confronting them.

The California Conference of Local Mental Health Officers was organized in November 1958 with Dr. W. E. Turner of Santa Clara County as its first chairman. This conference, acting jointly with the State Department of Mental Hygiene, evaluates and approves the local mental health programs, and establishes the regulations for their operation.

On July 13, 1957, Dr. Frank A. MacDonald, then president of the California Medical Association, wrote:

"The California Medical Association believes that the Short-Doyle Act (Senate Bill No. 244) which permits psychiatric patients to be treated in general hospitals, which heretofore have infrequently included psychiatric wards, will improve the care of patients with emotional and mental disorders.

"This act should permit more effective treatment in the early stages of the disorder, should allow closer liaison between various medical specialists and should assist the patient mentally by allowing him to obtain complete psychiatric care in his home community, close to his family, his employment and his personal physician."

Any general hospital wishing to establish an inpatient or outpatient psychiatric service, or to enter a local mental health services program if it already has such services, may do so by entering into a contract with the local governing body. For example, San Francisco county in addition to expanding its county hospital services, plans to contract for psychiatric services with four private general hospitals (Children's, Mt. Zion, St. Mary's and St. Francis Memorial). It has long been recommended that general hospitals should allot up to 10 per cent of their beds for psychiatric patients, including alcoholic patients, and the Short-Doyle Act provides a means for accomplishing this. If such an allotment were made, psychiatrists would be encouraged to join hospital staffs and to participate in hospital activities with a mutual sharing of medical experience. The general hospital would become truly general, capable of caring for patients with illnesses of all kinds, both physical and mental. The hospital would man its psychiatric service the same as the medical, surgical or obstetrical service and would be responsible to the local director of the mental health services only for services contracted for with the community.

All the elements in the programs being carried on under the Short-Doyle Act, both at county and state levels, are developing a closer relationship with the county and state medical societies. The C.M.A. Committee on Mental Health meets at regular intervals with the chairmen of the mental health committees of the county medical societies, with the personnel of the local programs and with representatives of the State Department of Mental Hygiene.

In adopting this program, California has struck out in a bold new attack on mental illness. It is probable that more and more general hospitals will make arrangements for care of psychiatric patients with inpatient, outpatient and rehabilitation services. With both the medical profession and the general public becoming oriented to the newer techniques in psychiatry, earlier diagnosis and treatment can be expected. In the last few years the discharge rate from mental hospitals across the country has exceeded the admission rate and this trend should accelerate in coming years as more treatment is provided in the local community.

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